St. Paul's Home for the Aged
IDPH Facility ID# 0013920
01/01/01-12/31/01

		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0013920

Facility Name: St Paul's Home

Address: P. O. Box 347, 1021 West "E" St. (Number) Belleville, IL (City) 62220 (Zip Code)

County: St. Clair

Telephone Number: (618)233-2095 **Fax #** (618)233-2109

IDPA ID Number: 37-0681517001

Date of Initial License for Current Owners: unable to locate

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 © 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Shirley Saia **Telephone Number:** 618-233-2095

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Arthur H. Peters
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

St. Paul's Home for the Aged
IDPH Facility ID# 0013920
01/01/01-12/31/01

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home **#** 0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	113	Intermediate (ICF)	113	41,245	3
4		Intermediate/DD			4
5	62	Sheltered Care (SC)	62	22,630	5
6		ICF/DD 16 or Less			6
7	175	TOTALS	175	63,875	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	25,228	14,230		39,458	10
11	ICF/DD					11
12	SC	2,098	9,402		11,500	12
13	DD 16 OR LESS					13
14	TOTALS	27,326	23,632		50,958	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.78%

D. How many bed-hold days during this year were paid by Public Aid?
239 **(Do not include bed-hold days in Section B.)**

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1926

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 **Fiscal Year:** _____

*** All facilities other than governmental must report on the accrual basis.**

St. Paul's Home for the Aged
IDPH Facility ID# 0013920
01/01/01-12/31/01

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	270,052	24,748	31,397	326,197		326,197		326,197			1
2	Food Purchase		238,545		238,545		238,545		238,545			2
3	Housekeeping	239,900	37,254		277,154		277,154		277,154			3
4	Laundry	121,999	16,692		138,691		138,691		138,691			4
5	Heat and Other Utilities			210,873	210,873		210,873		210,873			5
6	Maintenance	75,465	22,277	38,874	136,616	240	136,856		136,856			6
7	Other (specify):* Security	14,417			14,417		14,417		14,417			7
8	**TOTAL General Services**	721,833	339,516	281,144	1,342,493	240	1,342,733		1,342,733			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,375,923	25,070	98,211	1,499,204		1,499,204		1,499,204			10
10a	Therapy	70,914		7,762	78,676		78,676		78,676			10a
11	Activities	57,560	3,509	2,237	63,306	30	63,336		63,336			11
12	Social Services	34,274	58	1,002	35,334		35,334		35,334			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,538,671	28,637	115,212	1,682,520	30	1,682,550		1,682,550			16
	C. General Administration											
17	Administrative	75,126			75,126		75,126		75,126			17
18	Directors Fees											18
19	Professional Services			38,680	38,680		38,680	(500)	38,180			19
20	Dues, Fees, Subscriptions & Promotions			19,452	19,452		19,452	(4,774)	14,678			20
21	Clerical & General Office Expenses	191,650	27,115	14,478	233,243		233,243		233,243			21
22	Employee Benefits & Payroll Taxes			621,581	621,581		621,581		621,581			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,351	4,351		4,351		4,351			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,574	57,574		57,574		57,574			26
27	Other (specify):*			63,123	63,123	(270)	62,853	(44,255)	18,598			27
28	**TOTAL General Administration**	266,776	27,115	819,239	1,113,130	(270)	1,112,860	(49,529)	1,063,331			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,527,280	395,268	1,215,595	4,138,143		4,138,143	(49,529)	4,088,614			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home #0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			186,196	186,196		186,196		186,196			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,150	75,150		75,150		75,150			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			261,346	261,346		261,346		261,346			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,951	2,951		2,951		2,951			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,867	61,867		61,867		61,867			42
43	Other (specify):* **Van Driver**	7,665			7,665		7,665		7,665			43
44	**TOTAL Special Cost Centers**	7,665		64,818	72,483		72,483		72,483			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,534,945	395,268	1,541,759	4,471,972		4,471,972	(49,529)	4,422,443			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home **# 0013920** **Report Period Beginning: 01/01/01** **Ending: 12/31/01**

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	550	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	38,891	27		24
25	Fund Raising, Advertising and Promotional	1,921	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	2,717	20		28
29	Other-Attach Schedule see page 5A	5,450			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 49,529		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 49,529		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

St Paul's Home

ID# 0013920

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Newsletter Expense	$ (4,510)	27	1
2	Dues to Civic Organization	(136)	20	2
3	Compliance Ad Cost	(98)	27	3
4	Miscellaneous Sundry Items	(206)	27	4
5	Appraisal Fees	(500)	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,450)		49

St. Paul's Home for the Aged
IDPH Facility ID# 0013920
01/01/01-12/31/01

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number St Paul's Home **#** 0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(500)	0	0	0	0	0	0	0	0	0	0	(500)	19
20	Fees, Subscriptions & Promotions	4,502	0	0	0	0	0	0	0	0	0	0	4,502	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	34,627	0	0	0	0	0	0	0	0	0	0	34,627	27
28	**TOTAL General Administration**	38,629	0	0	0	0	0	0	0	0	0	0	38,629	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	38,629	0	0	0	0	0	0	0	0	0	0	38,629	29

St. Paul's Home for the Aged
IDPH Facility ID# 0013920
01/01/01-12/31/01

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **St Paul's Home** **# 0013920** **Report Period Beginning:** **01/01/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	38,629	0	0	0	0	0	0	0	0	0	0	38,629	45

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Facility Name & ID Number **St Paul's Home** **#** **0013920** **Report Period Beginning:** **01/01/01** **Ending:** **12/31/01**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Union Planters Bank		X	Real Estate Mortgage	$5,486.00	12/15/00	$ 636,144	$ 626,400	6/13/05	0.0875	$ 54,289	1
2	Union Planters Bank		X	Real Estate Mortgage		6/28/01		21,498	6/13/05	0.0875	909	2
3												3
4												4
5	Interest Income										(1,382)	5
	Working Capital											
6	Union Planters Bank		X	Provide operating funds		6/15/00	175,000	175,000	6/15/01	0.1000	7,513	6
7	Union Planters Bank		X	Provide operating funds		6/15/01	175,000	175,000	6/15/02	0.0550	6,273	7
8	St. Paul's Home Foundation	X		Provide operating funds		1/18/00	63,500	263,500	1/18/02	0.0450	7,548	8
9	TOTAL Facility Related				$5,486.00		$ 1,049,644	$ 1,261,398			$ 75,150	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,049,644	$ 1,261,398			$ 75,150	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ Exempt	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ Exempt	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ Exempt	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996		8
	1997		9
	1998		10
	1999		11
	2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Paul's Home COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0013920

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 56,032 B. General Construction Type: Exterior Brick Frame _____ Number of Stories see attached

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

St. Paul's Home for the Aged Retirement Community, independent living apartments, 62,500 square feet, 53 apartments.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use	178,000	1926	$ 16,901	1
2	Resident Use	Land Improvements	1995	5,310	2
3	TOTALS	#VALUE!		$ 22,211	3

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	30		1960	1960	$ 166,566	$	25	$	$	$ 166,566	4
5	32		1957	1957	148,250	2,968	50	2,968		130,452	5
6	38		1962	1962	266,977	5,909	50	5,909		208,019	6
7	75		1971	1971	654,498	15,997	40	15,997		503,593	7
8			1981	1981	718,105	18,313	40	18,313		385,726	8
	Improvement Type**										
9				1961	14,618		25			14,618	9
10				1963	594		25			594	10
11				1971	40,791		25			40,791	11
12				1973	1,471		25			1,471	12
13				1974	1,162		20			1,162	13
14				1975	7,723		25			7,723	14
15				1976	75,275	2,015	35	2,015		55,974	15
16				1977	13,703		10			13,703	16
17				1978	24,680		15			24,680	17
18				1979	454,801	15,932	30	15,932		342,227	18
19				1980	5,908		20			5,908	19
20				1982	44,406	1,866	10	1,866		40,349	20
21				1983	6,581		10			6,581	21
22				1984	8,251		10			8,251	22
23				1985	2,786		10			2,786	23
24				1986	17,208	691	20	691		10,572	24
25				1987	169,475	7,439	20	7,439		124,018	25
26				1989	38,131	2,542	15	2,542		31,775	26
27				1991	109,995	4,470	20	4,470		62,706	27
28				1992	54,380	3,866	10	3,866		40,317	28
29				1993	6,300	252	25	252		2,268	29
30				1994	45,495	3,119	15	3,119		24,242	30
31				1995	21,589	2,159	10	2,159		15,113	31
32	Repaved parking lot/sidewalk improvements			1996	19,616	1,699	15	1,699		9,345	32
33	Dishroom renovation and door installation			1996	38,379	2,009	20	2,009		11,964	33
34	Remodeled administrative office area			1996	9,218	615	15	615		3,356	34
35	Installation of fences			1996	4,099	410	10	410		2,460	35
36	Supplemental lighting for parking lot			1997	1,225	82	10	82		410	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Ashpahlt driveway improvements	1997	$ 11,065	$ 1,362	10	$ 1,362	$	$ 6,129	37
38	Building for emergency generator	1997	33,000	1,000	33	1,000		5,000	38
39	Structural improvements to Kohl Wing	1997	21,878	1,286	20	1,286		5,995	39
40	Installation of fences	1997	1,823	182	10	182		819	40
41	Telephone alcove and construction of wall divider	1997	3,690	246	15	246		1,230	41
42	Internal corridor doors	1997	4,118	412	10	412		2,060	42
43	Remodeling/redecorating of resident rooms/areas	1997	29,198	2,920	10	2,920		14,600	43
44	Aluminum ramp/brackets for porch area	1998	1,121	224	5	224		784	44
45	Tuckpointing/caulking of retaining wall	1998	2,500	313	8	313		1,095	45
46	Soffitt/fascia installation	1998	13,194	660	20	660		2,310	46
47	Wallcovering (Emplovee dining room and main corridor)	1998	2,765	277	10	277		1,108	47
48	Roof replacement (Kohl wing)	1998	31,078	2,179	10	2,179		7,627	48
49	Remodeling of shower room (Kohl wing)	1998	3,836	384	10	384		1,344	49
50	Roof repairs (Ludwig wing)	1998	1,620	162	10	162		567	50
51	Shelter Nurses' station renovation	1999	7,194	719	10	719		2,157	51
52	Structural repairs to Kohl Wing	1999	1,988	199	10	199		597	52
53	Shower stall and flooring replacements (Kohl wing)	1999	4,418	442	10	442		1,326	53
54	Panic hardware for Ludwig front door	1999	527	106	5	106		264	54
55	Bartel wing lighting	1999	5,034	503	10	503		1,258	55
56	Valves for domestic water line	1999	1,927	193	10	193		482	56
57	Water supply lines for cooling tower	1999	592	59	10	59		148	57
58	Chapel roof repairs	1999	3,025	302	10	302		767	58
59	Bartel wing soiled linen room remodeling	2000	7,860	524	15	524		1,048	59
60	Heater covers for front entry and main corridor	2000	1,209	121	10	121		181	60
61	Replacement of Bartel wing sewer line	2000	16,237	812	20	812		1,624	61
62	Kitchen lighting project	2001	13,493	675	20	675		675	62
63	Exit seeker system	2001	10,767	1,077	10	1,077		1,077	63
64	Ludwig wing sewer project	2001	12,719	318	20	318		318	64
65	Master antennae system (Bartel wing)	2001	2,149	107	10	107		107	65
66	Window Project (Bartel wing)	2001	22,442	449	25	449		449	66
67	Laundry dedicated electrical circuit	2001	840	42	10	42		42	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,465,563	$ 110,608		$ 110,608	$	$ 2,362,908	70

**Improvement type must be detailed in order for the cost report to be considered complete

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 846,096	$ 70,391	$ 70,391	$		$ 474,107	71
72	Current Year Purchases	8,862	1,181	1,181			1,181	72
73	Fully Depreciated Assets	591,557	3,368	3,368			591,557	73
74								74
75	TOTALS	$ 1,446,515	$ 74,940	$ 74,940	$		$ 1,066,845	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van/Improvements	Ford 1985	1985	$ 26,794	$	$	$	5	$ 26,794	76
77	Van	Ford 1992	1995	11,560				5	11,560	77
78	Van/Improvements	Ford 1992 (lift)	1996	3,595				5	3,595	78
79	Van/Improvements	Ford 1985	1997	3,240	648	648		5	2,916	79
80	TOTALS			$ 45,189	$ 648	$ 648	$		$ 44,865	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,979,478	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 186,196	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 186,196	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,474,618	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Parking Lot Improvments	$ 955	92
93	Furniture(not in service)	173	93
94			94
95		$ 1,128	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   St. Paul's Home only hires CNA's that have already completed a certified nurse aide training program and are curretnly listed on the Illinois CNA registry.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a 3	hrs	$	3	$ 164	$	3	$ 164	1
2	Licensed Speech and Language Development Therapist	10a 3	hrs		19	555		19	555	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a 3	hrs		262	7,043		262	7,043	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	284	$ 7,762	$	284	$ 7,762	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

St. Paul's Home for the Aged
IDPH Facility ID# 0013920
01/01/01-12/31/01

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** ######## **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 29,295	$ 64,271	1
2	Cash-Patient Deposits	5,328	7,070	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	368,486	382,671	3
4	Supply Inventory (priced at cost)	25,770	31,521	4
5	Short-Term Investments	136,267	145,656	5
6	Prepaid Insurance	1,880	2,358	6
7	Other Prepaid Expenses	1,213	1,333	7
8	Accounts Receivable (owners or related parties)	105,742	380,742	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 673,981	$ 1,015,622	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,303	1,023,958	12
13	Land	22,696	443,326	13
14	Buildings, at Historical Cost	3,465,563	8,447,967	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,491,705	1,795,324	16
17	Accumulated Depreciation (book methods)	(3,474,618)	(5,346,081)	17
18	Deferred Charges	4,953	11,010	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Constr. In Progress	1,128	2,085	22
23	Other(specify):	115,830	128,700	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,633,560	$ 6,506,289	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,307,541	$ 7,521,911	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 125,783	$ 132,575	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,587	74,982	28
29	Short-Term Notes Payable	29,419	140,761	29
30	Accrued Salaries Payable	113,819	123,908	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,826	10,826	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,611	19,282	33
34	Deferred Compensation	26,838	63,873	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Line of Credit	175,000	175,000	36
37	Advances from Non Care Operations	263,500	380,742	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 751,383	$ 1,121,949	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	618,479	3,585,570	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 618,479	$ 3,585,570	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,369,862	$ 4,707,519	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 937,679	$ 2,814,392	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,307,541	$ 7,521,911	48

***(See instructions.)**

Facility Name & ID Number St Paul's Home # 0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,941,183	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,941,183	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(89,635)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	56,649	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)	(93,805)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (126,791)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,814,392	24 *

*** This must agree with page 17, line 47.**

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,171,373	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,171,373	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	175,000	24
25	Interest and Other Investment Income***	40	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 175,040	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See attachment	35,924	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 35,924	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,382,337	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,342,493	31
32	Health Care	1,682,520	32
33	General Administration	1,113,130	33
	B. Capital Expense		
34	Ownership	261,346	34
	C. Ancillary Expense		
35	Special Cost Centers	10,616	35
36	Provider Participation Fee	61,867	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,471,972	40
41	**Income before Income Taxes (line 30 minus line 40)****	(89,635)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (89,635)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not for Profit If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

STATE OF ILLINOIS

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,816	2,344	$ 50,275	$ 21.45	1
2	Assistant Director of Nursing	1,848	2,180	43,933	20.15	2
3	Registered Nurses	9,176	10,317	169,454	16.42	3
4	Licensed Practical Nurses	26,296	28,698	390,617	13.61	4
5	Nurse Aides & Orderlies	76,078	81,629	721,642	8.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,741	7,284	70,914	9.74	8
9	Activity Director	1,078	1,146	19,691	17.18	9
10	Activity Assistants	4,344	4,574	37,869	8.28	10
11	Social Service Workers	3,230	3,522	34,274	9.73	11
12	Dietician					12
13	Food Service Supervisor	2,034	2,262	40,572	17.94	13
14	Head Cook	1,835	1,933	15,119	7.82	14
15	Cook Helpers/Assistants	9,305	10,128	93,157	9.20	15
16	Dishwashers	18,435	19,692	121,204	6.15	16
17	Maintenance Workers	8,655	9,456	75,465	7.98	17
18	Housekeepers	28,564	31,937	239,900	7.51	18
19	Laundry	15,834	17,178	121,999	7.10	19
20	Administrator	2,494	2,650	75,126	28.35	20
21	Assistant Administrator					21
22	Other Administrative	2,169	2,414	48,558	20.12	22
23	Office Manager	2,102	2,342	41,078	17.54	23
24	Clerical	11,826	12,998	102,014	7.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Van Driver & Secu	2,803	3,079	22,084	7.17	33
34	TOTAL (lines 1 - 33)	236,663	257,763	$ 2,534,945 *	$ 9.83	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	160	$ 7,111	1/3	35
36	Medical Director	as needed	6,000	9/3	36
37	Medical Records Consultant	12	420	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,210	10/3	39
40	Physical Therapy Consultant	262	7,043	10/3	40
41	Occupational Therapy Consultant	3	164	10/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	19	555	10/3	43
44	Activity Consultant	47	2,237	11/3	44
45	Social Service Consultant	21	1,002	12/3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	620	$ 25,742		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	5,636	96,581	10/3	52
53	TOTAL (lines 50 - 52)	5,636	$ 96,581		53

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Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arthur H. Peters	Pres/Administrator	0	$ 75,126
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,126

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Automatic Data Processing	Payroll Services	$ 10,973
Greensfelder,Hemker and Gale	Legal Services	18,252
Thompson Coburn	Legal Services	2,093
Rice Sullivan and Co., Ltd	Audit Services	6,862
Tade Appraisal Co.	Appraisal Services	500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 38,680

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 119,289
Unemployment Compensation Insurance	15,020
FICA Taxes	191,191
Employee Health Insurance	259,536
Employee Meals	30,660
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations Expense	5,885
TOTAL (agree to Schedule V, line 22, col.8)	$ 621,581

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,147
Health Care Worker Background Check (Indicate # of checks performed 59)	708
Newspapers and Subscriptions	1,316
Life Services Network	6,407
Promotion and Advertising	4,638
Administrator's License	100
Civic Organization Dues	136
Civic Organization Dues	(136)
Less: Public Relations Expense	( )
Non-allowable advertising	(1,921)
Yellow page advertising	(2,717)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,678

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	759
Seminar Expense	3,592
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,351

**See instructions.

Facility Name & ID Number St Paul's Home # 0013920 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Interior Repainting	10/97	$ 988	36	$ 324	$ 324	$ 259	$	$	$	$	$	$
2	Interior Repainting	3/97	15,077	36	5,040	5,040	1,217						
3	Interior Repainting	4/98	1,720	36	432	576	576	136					
4	Interior Repainting	10/98	763	36	63	252	252	196					
5	Interior Repainting	10/98	2,832	36	237	948	948	699					
6	Interior Repainting	12/98	560	36	16	192	192	160					
7	Interior Repainting	1/99	130	36		48	48	34					
8	Interior Repainting	1/99	360	36		120	120	120					
9	Interior Repainting	1/99	540	36		180	180	180					
10	Interior Repainting	4/00	134	36			36	48	50				
11	Interior Repainting	9/00	172	36			20	60	60	32			
12	Interior Repainting	9/00	135	36			16	48	48	23			
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 23,411		$ 6,112	$ 7,680	$ 3,864	$ 1,681	$ 158	$ 55	$	$	$

Facility Name & ID Number St Paul's Home # 0013920 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $6407**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **20 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **2,771** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **61,867**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **30,660** Has any meal income been offset against
related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Rice Sullivan and Co., Ltd.** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

St. Paul's Home for the Aged
IDPH Facility ID# 0013920
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Schedule V, Line 27, Column 3, Page 3

Title Search Cost	$ 210.00
Newsletter	4,510.00
Calendars	1,220.00
Sundry expenses and incidental supplies	206.00
Volunteer recognition	441.00
"Compliance" ad cost	98.00
Bad Debt/Charity Care expense	38,891.00
Items to be reclassified	270.00
Contributions to Life Services Network	550.00
Medicare Certification study	3,857.00
Amortization of membership dues in Senior Care Network	12,870.00
	63,123.00

Line 27, Column 5-Reclassification

Reclassification to maintenance "other"	(240.00)
Reclassification to activities supplies	(30.00)
	(270.00)

Summary of Miscellaneous Sundry Account, Line 27

Medicare Certification study	3,857.00
Amortization of membership dues in Senior Care Network	12,870.00
Title search cost for refinancing	210.00
Calendars	1,220.00
Volunteer recognition	441.00
	18,598.00

Reclassification, Column 5

All reclassifications were made to meet requirements set forth in cost report instructions. Original General Ledger distributions were made according to internal accounting policies of St. Paul's Home for the Aged

St. Paul's Home for the Aged
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Summary of legal services (copies of invoices attached)

Statement dated February 28, 2001 Legal services regarding Corporate matters	$ 149.50
Statement dated March 30, 2001 Legal services regarding employee matters	1,487.17
Statement dated March 30, 2001 Legal services regarding employee matter	95.16
Statement dated March 30, 2001 Legal services regarding employee matters Legal services regarding responses to Accountant's request for information for audit report	697.13
Statement dated April 17,2001 Legal services regarding employee matters	1,028.97
Statement dated May 31, 2001 Legal services regarding resident and Corporate matters	618.91
Statement dated June 30, 2001 Legal services regarding employee matters	2,310.90
Statement dated July 24, 2001 Legal services regarding employee matters and resident matters	943.50
Statement dated July 24, 2001 Legal services regarding employee matters	108.23
Statement dated August 31, 2001 Legal services regarding employee matters	788.50
Statement dated September 28, 2001 Legal services regarding employee matters	1,517.70
Statement dated October 31, 2001 Legal services regarding resident matters	4,056.30
Statement dated November 30, 2001 Legal services regarding resident matters and Corporate matters	1,155.62
Statement dated January 18, 2002 Legal services regarding employee issues	274.90
Statement dated January 29, 2002 Legal services regarding Corporate matters and resident matters	5,112.16
Total legal services	$ 20,344.65

St. Paul's Home for the Aged
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Attachment to Schedule VII, Related Parties

St. Paul's Home for the Aged Board of Directors

Mrs. Karen Buehler, Chairperson
Mr. Kenneth Nettleton, Vice Chairperson
Mr. Cary Smith, Treasurer
Mrs. Mona Scheibel, Secretary
Mr. William Lindauer, Director
Mr. Belmont Valentine, Jr., Director
Mr. James Wallace, Director
Mr. Charles Weik, Director
Rev. Ann Asper Wilson, Director

All officers and directors listed above receive no compensation and serve on a voluntary basis and donate whatever time is necessary on a part time basis.

St. Paul's Home for the Aged
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01/01/01-12/31/01

ATTACHMENT TO SCHEDULE X, BUILDING AND GENERAL INFORMATION

Schedule X, A, Number of Stories

Nursing Facility is comprised of 6 buildings:
- 2 Building are 2 stories
- 4 Buildings are 1 story, 3 of which have basements

ATTACHMENT TO SCHEDULE XI, OWNERSHIP COSTS

Schedule XI, A, Land, Line 1, Column 4

General ledger balance of $17,386 reduced to $16,901 by 1982 audit

St. Paul's Home for the Aged
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ATTACHMENT TO SCHEDULE XV, BALANCE SHEET, Line 34, COLUMN 1 AND 2

Account title should be Deferred Revenue, not Deferred Compensation

ATTACHMENT TO SCHEDULE XVI, STATEMENT OF CHANGES IN EQUITY

Total Additions (Deductions), Line 15, Column 1

Apartment Community	$ (28,806.00)
Foundation (net of bequest and memorial gifts	(54,400.00)
Non care related property (net)	(10,599.00)
	$ (93,805.00)

ATTACHMENT TO SCHEDULE XVII, INCOME STATEMENT

Interest and Other Investment Income, Line 25, Column, 1

Dividend Income	$ 40.00

Other Income, Line 28, Column 1

Activity Income	$ 936.00
Administrative support income	8,000.00
Dividend from Workers' Compensation Carrier	24,938.00
Miscellaneous other income	374.00
Late fee income	1,676.00
	$ 35,924.00

ATTACHMENT OF SCHEDULE XX, GENERAL INFORMATION, 12

Salary of van driver to take residents to doctors, labs and hospitals